MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09863

09862 CERTIFICATE OF DEATH Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 40 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 310 Maryland Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) 310 Maryland

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) (Last) Abbott

4. DATE OF DEATH: (Month) 10 (Day) 25 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Dec. 14, 1888

9. AGE last birthday: 66 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Self-Employed

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Abbott

14. MOTHER'S MAIDEN NAME: Caroline Malone

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service) —

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Lillie Abbott - Same.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Coronary — Interval Between Onset And Death: Few minutes

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

420.1

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at ....., from the causes and on the date stated above.

SIGNATURE (Degree or title) Andrew C Mitchell MD ADDRESS 225 N. Divine Salisbury DATE SIGNED 10/28/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 10/28/54 NAME OF CEMETERY OR CREMATORY Parsons Cemetery LOCATION (City, town, or county) (State) Salisbury, Maryland

DATE REC'D BY LOCAL REGISTRAR 10-28-54 REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR The Hill & Johnson Co. ADDRESS Salisbury, Md
George C. Hill Jr

RECEIVED
NOV 1 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Burton 09863

CERTIFICATE OF DEATH

09864

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Salisbury — LENGTH OF STAY (in this place) 12
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hosp. 30

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico
STREET ADDRESS (If rural give location) R. D. # 5 General Delivery

3. NAME OF DECEASED: (Type or Print) (First) Ratie (Middle) (Last) ALEXANDER

4. DATE OF DEATH: (Month) 10 (Day) 31 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: Nov. 2, 1887

9. AGE last birthday: 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) House Work

10b. KIND OF BUSINESS OR INDUSTRY: At Own Home

11. BIRTHPLACE (State or foreign country): Georgetown Del.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaiah Campbell

14. MOTHER'S MAIDEN NAME: Mary Wingate

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mr. Harvy Campbell (Brother) 506 E. Isabella St. Salisbury, Maryland

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (443X)	(a) Cerebral thrombosis	5 hours
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Previous cerebral thrombosis.	9 days
	DUE TO (c) Hypertension. Arteriosclerotic vascular disease.	4 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Auricular fibrillation.	? Years.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1954, to 10/31, 1954, that I last saw the deceased alive on 10/31, 1954, and that death occurred at 11.25 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) M.D. — ADDRESS Salisbury — DATE SIGNED 10/31/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Nov 4, 1954 — NAME OF CEMETERY OR CREMATORY Athol Baptist Cemetery — LOCATION (City, town, or county) (State) Near Hardela Md. (Athol Md.)

DATE REC'D BY LOCAL REGISTRAR 11-4-54 — REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR HOLLOWAY & COMPANY — ADDRESS SALISBURY MARYLAND

Walter R. Holloway

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NOV 8 19[illegible]
BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Salisbury 12
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS City Park water stream

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural, give location) R.D. # 3

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
LAURA	ELINOR	BAILEY	OCT	9 th	19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	June 22, 1879	75 yrs.	3	17		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
House Work	At Home	Salisbury, Maryland R.D.#	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Thomas E. Oliphant	Elizabeth Freeny

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
NO		Mrs. Herman Voigt (Daughter) Salisbury, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning — —
DUE TO
Antecedent cause(s) (b)
Diseases or conditions, if any, giving rise to the above cause DUE TO
stating underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY?
		Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY City Park	21c. (City or town) Salisbury	(County) Wicomico	(State) Md

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10 9 54 7 P.M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR? Found Drowned

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☒.

SIGNATURE Earl L Bryan M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED 10-11-54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 12, 1954	Parsons Cemetery	Salisbury Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-11-54	Mary W. Holloway	HOLLOWAY & COMPANY	SALISBURY MARYLAND

Walter R. Holloway

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OCT 13 1954
BUREAU V. S.

09865 09866

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Medical Examiner's **CERTIFICATE OF DEATH**

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

1. PLACE OF DEATH:
   COUNTY Wicomico — MARYLAND
   CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury 12
   LENGTH OF STAY (in this place) 3 days
   HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula Gen. Hosp. 20

2. USUAL RESIDENCE (HOME) OF DECEASED:
   STATE Delaware — COUNTY Sussex
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Delmar 46 x 3
   STREET ADDRESS (If rural give location) 304 Grove Street ✓

3. NAME OF DECEASED: (Type or Print) (First) Garley (Middle) Wilson (Last) Baker

4. DATE OF DEATH: (Month) Oct. (Day) 14, (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	3-25-1897	57 yrs.		

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic	General	Willards, Md.	USA

13. FATHER'S NAME: George A. Baker

14. MOTHER'S MAIDEN NAME: Alice Burton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT & ADDRESS
No	221-22-2243	Virginia Baker, Delmar, Del.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Congestive Cardiac Failure and Surgical Shock — minutes

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Compression & Chest by Kyphoscoliosis of Spine — 33 years
DUE TO (c) during Cystotomy for Carcinoma of Urinary Bladder

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Oct. 14, 1954	Carcinoma of Urinary Bladder,	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
natural	hospital	Salisbury	Wicomico	Maryland

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☒	HOW DID INJURY OCCUR?
Oct 14 1954 3:57 p.m.		death under general anesthesia

22. I hereby certify that I ~~attended~~ the deceased ~~from~~ Oct. 14, 1954 ~~to~~ 19—, ~~that~~ I last saw the deceased ~~alive~~ dead on Oct. 14, 1954, and that death occurred at 3:57 pm, from the causes and on the date stated above.

SIGNATURE (Degree or title) Kendrick McCullough M.D. acting deputy medical examiner for Wicomico Co. ADDRESS Parsonsburg Md. DATE SIGNED Oct. 14, 1954

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY ~~OR CREMATORY~~	LOCATION (City, town, or county) (State)
Burial	10-17-54	Mt Olive	Delmar, Del.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-18-54	Mary W. Holloway	W. S. Ingram Co.	Delmar, Del

VS. A15

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OCT 20 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09866 **CERTIFICATE OF DEATH** 09867

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula Gen. Hosp. 20

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Willards
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) (Last) Beachm

4. DATE OF DEATH: (Month) 10 (Day) 10 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH:
9. AGE last birthday: 30 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Hospital Record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 2040

Immediate cause (a) Acute Lymphoblastic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1954, to Oct 11, 1954, that I last saw the deceased alive on Oct. 11, 1954, and that death occurred at 10:40 P.m., from the causes and on the date stated above.

SIGNATURE David J. Gilmore (DEGREE OR TITLE) Mr D. ADDRESS Salisbury Md. DATE SIGNED Oct. 11, 1954

23. BURIAL, CREMATION REMOVAL (Specify): Removal
DATE THEREOF Oct 12, 1954
NAME OF CEMETERY OR CREMATORY Anatomical Bd
LOCATION (City, town, or county) Balto. Md. (State)

DATE REC'D BY LOCAL REG. 10-12-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Booker Nt West ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

RECEIVED
OCT 14 1954
BUREAU V[illegible]

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Item 21f Filmed 72 10-28-54 ars

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. .....

1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Route # 13

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Somerset

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Mt. Vernon

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Wade	Drewer	Bloodsworth	October 15 19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Aug 8, 1919	75 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Truck Driver		Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Walter W. Bloodsworth	Mary Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
		Mrs. Virginia Bloodsworth, Mt. Vernon, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Crushed skull	
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)	(State)
		Salisbury	Wicomico	Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☑	21f. HOW DID INJURY OCCUR?
10 15 1954 5:30 P.M.		Struck by Roof of Bldg during Hurricane

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Earl L Bryan M. D. Salisbury

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☑

DATE SIGNED 10-16-54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 18, 54	Asbury Cemetery	Mt. Vernon, Md.

DATE RECD. BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/19/54	Mary M. Holloway - asst.	Thomas F. Wallace	Salisbury, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

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MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hebron
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Walnut Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hebron
STREET ADDRESS (If rural, give location): Walnut street

3. NAME OF DECEASED (Type or Print): (First) GEORGE (Middle) EDWARD (Last) Bonneville

4. DATE OF DEATH: (Month) 10 (Day) 19 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 27, 1881

9. AGE last birthday: 73 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired (Lumber mill)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas T. Bonneville

14. MOTHER'S MAIDEN NAME: Ermie Hargis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY No.: 212-10-8960

17. INFORMANT AND ADDRESS: William E. Bonneville

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Coronary Thrombosis — Interval between onset and death: 1 hour

Antecedent cause (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b):

(c): Coronary artery arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cardiac failure following coronary thrombosis — 1 month

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/20, 1954, to death, 19....., that I last saw the deceased alive on 10/18, 1954, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

SIGNATURE: Ernest M. Larmon (Degree or title) M.D. ADDRESS: Delmar Del DATE SIGNED: 10/19/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 10-21-54
NAME OF CEMETERY OR CREMATORY: Parksley Cemetery
LOCATION (City, town, or county): Parksley
(State): Va

DATE REC'D BY LOCAL REG.: 10-19-54
REGISTRAR'S SIGNATURE: Mary M. Holloway

24. FUNERAL DIRECTOR: Lacy P. Sparrow
ADDRESS: Accomac Va

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OCT
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09870

09867 CERTIFICATE OF DEATH Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Salisbury, Md.
LENGTH OF STAY (in this place) Since 1/5/54
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine Bluff State Hospital Salisbury, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Princess Anne, Md.
STREET ADDRESS (If rural give location) RFD #1

3. NAME OF DECEASED: (Type or Print) (First) Ellis (Middle) Addie (Last) Bozman

4. DATE OF DEATH: (Month) Oct (Day) 4 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Dec. 18, 1880

9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Princess Anne, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac J. Bozman

14. MOTHER'S MAIDEN NAME: Alaline Wallace

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Alva B. Parks, Princess Anne, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chr. Nephritis (uremic poisoning) DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Pulmonary Tuberculosis DUE TO

(c)

Interval Between Onset And Death: 10 yr. (illegible)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 5, 1954, to 10/4, 1954, that I last saw the deceased alive on 10/4, 1954, and that death occurred at . . . , from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

S. H. Bender M.D., Supt. Salisbury, Md. 10-6-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Oct 7, 1954 NAME OF CEMETERY OR CREMATORY Manie Cemetery LOCATION (City, town, or county) (State) Denton, Md

DATE REC'D BY LOCAL REGISTRAR 10-6-54 REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Leon R. Wilson ADDRESS Princess Anne, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 8 1914
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09871

Item 18 Film G171 10-18-54 ams 09868

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SALISBURY
LENGTH OF STAY (in this place) 2 Weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital 20

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SALISBURY
STREET ADDRESS (If rural, give location) 1023 SPRING AVE.

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) CHARLES Thomas BRADLEY

4. DATE OF DEATH: (Month) (Day) (Year) OCT. 5 1954

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Oct 3, 1892
9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith
10b. KIND OF BUSINESS OR INDUSTRY: Horse shoeing
11. BIRTHPLACE (State or foreign country): R.R. Cambridge, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William P. Bradley
14. MOTHER'S MAIDEN NAME: Edith Louise Le Compte

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 4 no
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Mrs. Mina H. Bradley, (wife) 1023 Spring Ave., Salisbury Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH 1 yr

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Primary Rectum

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 11
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-21, 1954, to 10-5, 1954, that I last saw the deceased alive on 10/5, 1954, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

SIGNATURE Fred R. Grance (DEGREE OR TITLE) M.D. ADDRESS Salisbury, Md DATE SIGNED 10/6/54

23. BURIAL, CREMATION REMOVAL (Specify): DATE THEREOF 10-8-54 NAME OF CEMETERY OR CREMATORY Parsons Cemetery LOCATION (City, town, or county) Salisbury, Md (State)

DATE REC'D BY LOCAL REG. 10-6-54 REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Holloway & Co., Salisbury Md ADDRESS Walter R. Holloway per MWH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1

RECEIVED
OCT 8 1954
BUREAU V. S.

09897 09872

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fruitland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS In transit to Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke City Md
STREET ADDRESS (If rural, give location) 723 - 6th St

3. NAME OF DECEASED (Type or Print) (First) Wilson (Middle) James (Last) Collins
4. DATE OF DEATH (Month) 10 (Day) 2 (Year) 1954
5. SEX M.
6. COLOR OR RACE C
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH Aug 13 1930
9. AGE last birthday 24 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Army life
10b. KIND OF BUSINESS OR INDUSTRY Regular Army
11. BIRTHPLACE (State or foreign country) Pocomoke City Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Wilson James Collins
14. MOTHER'S MAIDEN NAME Madora Winslow
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-22-1839
17. INFORMANT AND ADDRESS Madora Winslow Fong (Mother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Massive Internal Hemorrhage — Interval Between Onset and Death: Less than hour

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Puncture of Rt Ext Iliac Artery

(c) Bullet wound

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ✓ OR CONTRIBUTING CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Corn Street Pool Hall
(CITY OR TOWN) Pocomoke City (COUNTY) Worcester (STATE) Md
TIME OF INJURY (Month) 10 (Day) 2 (Year) 1954 (Hour) 10 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Shot during an Argument

22. I certify that I took charge of the remains described above, held an Autopsy ✓, Inspection ✓, Inquiry ✓ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ✓, undetermined ☐.

SIGNATURE N. E. Sartorius (Degree or title) Sr. Med Exam ADDRESS Pocomoke City Md DATE SIGNED 10/3/54

TIME OF CREMATION (Any specify) DATE THEREOF 10-8-54 NAME OF CEMETERY OR CREMATORY Fast Hill Cemetery LOCATION (City, town, or county) Pocomoke, Md (State)

DATE REC'D BY LOCAL REGISTRAR 10-9-54 REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Edgar Wharton - New Church, Va. ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age specially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09873

09898

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury X
LENGTH OF STAY (in this place) 8 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Cecil
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North East
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED: (Type or Print) (First) Sara (Middle) Victoria (Last) Dickens

4. DATE OF DEATH: (Month) Oct. (Day) 27 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Divorced
8. DATE OF BIRTH: 1/11/1881
9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Neva, Tenn.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Riley May
14. MOTHER'S MAIDEN NAME: Mollie Head

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO.: —
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
Immediate cause	(a)	Cardiac insufficiency	10 h
	DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	Arteriosclerotic heart disease	?
	DUE TO		
	(c)		

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Partial atelectasis, rt. lung ?

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/19, 1954, to 10/27, 1954, that I last saw the deceased alive on 10/27, 1954, and that death occurred at 00 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
S. Waldne, M.D. Salisbury Md. Deer's Head St. Hosp. 10/27/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF Oct 30-54
NAME OF CEMETERY OR CREMATORY Methodist
LOCATION (City, town, or county) (State) North East Cecil Co Md

DATE REC'D BY LOCAL REG. Nov. 3, 1954
REGISTRAR'S SIGNATURE Mary W. Holloway mnb.
24. FUNERAL DIRECTOR Joseph A. Graw North East Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

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BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09899 09874

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron X

LENGTH OF STAY (in this place) Most of life

HOSPITAL OR INSTITUTION OR STREET ADDRESS At home - Hebron, Md. Box 394 X

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron X

STREET ADDRESS (If rural give location) Hebron, Md. Box 394

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Harrison (Last) Ennis

4. DATE OF DEATH: (Month) 10 - (Day) 16 - (Year) 19 '54

5. SEX: Male

6. COLOR OR RACE: A.A.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: About 1883

9. AGE last birthday: About 71 yrs.

IF UNDER 1 YEAR: Months | Days

IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Mardela, Wicomico Co., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Ennis

14. MOTHER'S MAIDEN NAME: Anna Dashiell

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY No.: 214-32-3384

17. INFORMANT & ADDRESS: Mrs. Leah J. Ennis, Hebron, Md. Box 394

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Intestinal Hemorrhage — Interval Between Onset And Death: 3 days

DUE TO

Antecedent causes (s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 11, 1954, to Oct. 16, 1954, that I last saw the deceased alive on Oct. 16, 1954, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) William Ennis MD

ADDRESS Hebron Md.

DATE SIGNED Oct. 19-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 10-21-'54

NAME OF CEMETERY OR CREMATORY Mardela Cemetery

LOCATION (City, town, or county) (State) Mardela, Wicomico Co., Md.

DATE REC'D BY LOCAL REGISTRAR 10-20-54

REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Mary A. Stewart, 324 E. Church Street, Salisbury, Md.

ADDRESS

J. F. STEWART FUNERAL HOME

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (19875

09869

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
MARYLAND
LENGTH OF STAY (in this place) 30 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 214 West Vine St.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND
COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) 214 West Vine St.,

3. NAME OF DECEASED: (Type or Print) First LEE (Middle) SAMUEL (Last) EVANS

4. DATE OF DEATH: (Month) 10 (Day) 26 (Year) 1954

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH: DEC 20,
9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR Months IF UNDER 24 HRS. Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: BRICK MASON
10b. KIND OF BUSINESS OR INDUSTRY: BRICKS
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ARILLUS H. EVANS
14. MOTHER'S MAIDEN NAME: CATHERINE WINGATE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: 214-10-7678
17. INFORMANT & ADDRESS: HELEN E. EVANS, SAME

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) DUE TO Myocardial infarction

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO Previous myocardial infarction
(c) DUE TO Generalized arteriosclerosis. Hypertension.

Interval Between Onset And Death
1 day
2 days
years.

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/4/, 1954, to 10/25/ 1954, that I last saw the deceased alive on 10/25/, 1954, and that death occurred at 10:05 p.m., from the causes and on the date stated above.
SIGNATURE (Degree or title) M.D.
ADDRESS Salisbury
DATE SIGNED 10/27/54

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
DATE THEREOF 10/29/54
NAME OF CEMETERY OR CREMATORY Parsons Cemetery
LOCATION (City, town, or county) (State) Salisbury, Maryland

DATE REC'D BY LOCAL REGISTRAR 10-27-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Bethell & Johnson Co / George C. Hill II
ADDRESS Salisbury, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

OCT 29 1954

BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09876

09870

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Delaware — COUNTY Sussex

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Selbyville 4

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Wilmer	D.	Evans	10	4	1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White		May 9 1880	74 yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Retired Poultryman	Poultry	Delaware	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Samuel Evans	Jane Lynch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
No	none	Mrs Retha Evans, Selbyville, Del

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset And Death
Immediate cause	(a)	Myocardial Infarct, acute	12 days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO	Arteriosclerotic coronary thrombosis	"
	(c) DUE TO		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 9-22, 19 54, to 10-4, 19 54 that I last saw the deceased alive on 10-4, 19 54 and that death occurred at 3:05 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Willard R. Ellis, Jr. M.D.	Salisbury, Md.	10-7-54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	10-7-54	Bozanna Cemetery	Bozanna Del.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-4-54	Mary W. Holloway	Watson & Gray, Frankford, Del. Per M.W.H.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

OCT 6

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09871

CERTIFICATE OF DEATH

09877

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Salisbury — LENGTH OF STAY (in this place) 12

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Somerset

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Princess Anne

STREET ADDRESS R.F.D. #1 (If rural, give location)

3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
	Wilhelmina	Meurer	Felderhof	October	10	1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Married	Oct 5 1883	71 yrs				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Nurse	None	Holland	

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Phillips Meurer	Hendrina Wilhelmina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	No		Mr. Henry Felderhof Princess Anne Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Generalized Peritonitis	5 Days
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Adeno. Carcinoma of uterus	
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS:
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
—		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/9, 1954, to 10/10, 1954, that I last saw the deceased alive on 10/10, 1954, and that death occurred at 11 A.M., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
William S. Womack	M.D.	706 Camden Ave.	10/10/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct 13 1954	Asbury M.E. Cemetery	Mt. Vernon, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-13-54	Mary M. Holloway	Lewis R. Wilson	Princess Anne, Md

RECEIVED
OCT 15 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09878

09900 **CERTIFICATE OF DEATH** Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicimico MARYLAND md.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar
LENGTH OF STAY (in this place) Lep
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE md COUNTY Wicimico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar
STREET ADDRESS (If rural give location) Chestnut St

3. NAME OF DECEASED: (Type or Print) (First) Jerome (Middle) E (Last) Gordy
4. DATE OF DEATH: (Month) Oct (Day) 30 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH: July 30, 1869
9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Delmar
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Gordy
14. MOTHER'S MAIDEN NAME: Nancy Brumgton

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: —
17. INFORMANT & ADDRESS: Chantley Gordy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause 441 X (a) uremia in arteriosclerotic nephritis — 2 months
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO
(c) arteriosclerosis c̄ hypertension — 2 years

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypostatic pneumonia RLL — 3 months

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/1 ,1953, to death, 19....., that I last saw the deceased alive on 10/27, 1954, and that death occurred at ....., from the causes and on the date stated above.
SIGNATURE (Degree or title) Ernest M. Larmore M.D. ADDRESS Delmar, Del DATE SIGNED 10/31/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Nov 1 1954
NAME OF CEMETERY OR CREMATORY Union Cem
LOCATION (City, town, or county) Delmar md (State)
DATE REC'D BY LOCAL REGISTRAR 11-4-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Booker M West ADDRESS Salisbury md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

09879

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09901

CERTIFICATE OF DEATH

Reg. Dist. No. 322

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SALISBURY
LENGTH OF STAY (in this place) 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SALISBURY
STREET ADDRESS (If rural, give location) Rt. 4

3. NAME OF DECEASED: (Type or Print) (First) Rebecca (Middle) ELLA (Last) Gordy

4. DATE OF DEATH: (Month) Oct. (Day) 14th (Year) 1954

5. SEX: F.

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: FEB. 26th 1880

9. AGE last birthday: 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Wicomico, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ELIAH PARSONS

14. MOTHER'S MAIDEN NAME: Rebecca SHOCKLEY.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: HOSPITAL Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Cerebral thrombosis — Interval between onset and death: 9 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — DUE TO (b) Generalized arteriosclerosis — ?

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease, aortic stenosis ?

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/5, 1954, to 10/14, 1954, that I last saw the deceased alive on 10/14, 1954, and that death occurred at 7.20 A.m., from the causes and on the date stated above.

SIGNATURE Dr Guerman — (DEGREE OR TITLE) M.D. — ADDRESS Salisbury, Deer's Head State Hospital — DATE SIGNED 10/14/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF 10-18-54 — NAME OF CEMETERY OR CREMATORY Mt Olive Cem. — LOCATION (City, town, or county) R.D. #1 Worcester Co. — (State)

DATE REC'D BY LOCAL REG. 10-18-54 — REGISTRAR'S SIGNATURE Maryelle Holloway

24. FUNERAL DIRECTOR Holloway & C. — ADDRESS Salisbury Md.

RECEIVED
OCT 20 1
PEAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09872 (09880)

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Salisbury — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sharptown
STREET ADDRESS (If rural give location) Main St

3. NAME OF DECEASED: (First) Annie (Middle) (Last) Grauner
4. DATE OF DEATH: (Month) 10 (Day) 31 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Fem.	White	Widow	1869	85 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	none	MD	U.S.

13. FATHER'S NAME: Amos Bounds
14. MOTHER'S MAIDEN NAME: Elizabeth Bounds

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No		none	Mrs Alma Windsor

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
Immediate cause	(a) Cerebral Hemorrhage	17 hrs
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Cerebral Arteriosclerosis	
	DUE TO (c) Essential Hypertension	8 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Oct 31, 1954 to Oct 31, 1954; that I last saw the deceased alive on Oct 31, 1954, and that death occurred at 11 30 P, from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Raul L Gibson	M.D.	Salisbury Md	Oct 31 1954

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	11/4/54	Foreman	Sharptown	Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11-5-54	Mary W. Holloway	C. Paul Smith	Sharptown, Md

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09902

CERTIFICATE OF DEATH

09881

Reg. Dist. No. 332

Dr. Burton

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsburg
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. D. # 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsburg
STREET ADDRESS (If rural give location) R. D. # 1

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
JOSEPH	HENRY	GWATHMAY	OCT	27	19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married	June 29, 1879	75 yrs.	3	28		

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Sign Maker	Sign Co.	Richmond Va.	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
No Record	No Record

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No:	17. INFORMANT & ADDRESS:
Unk		Mrs. Lottie E. Gwathmay (Wife) R.D.# 1 Parsonsburg, Maryland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
Immediate cause	(a) Uraemia	2 days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Chronic interstitial	4 yrs
	DUE TO (c) Hypertension, generalized arteriosclerosis	4 yrs

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 9 5 ,19 54 , to 10 26 19 54 , that I last saw the deceased alive on 10 26 , 19 54 , and that death occurred at 6:00 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) L. D. ADDRESS Church & Broad Sts. Salisbury, Md. DATE SIGNED Oct 28 1954

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 30, 1954	St Michaels Cemetery	Astoria New York

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-28-54	Mary M. Holloway	HOLLOWAY & COMPANY	SALISBURY MARYLAND

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09873 (09882)

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Somerset

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Princess Anne

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Edward (Middle) (Last) Hayman

4. DATE OF DEATH: (Month) 10 (Day) 22 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Feb. 11, 1895

9. AGE last birthday: 59 yrs.

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Maintenance Man

10b. KIND OF BUSINESS OR INDUSTRY: Appliance Store

11. BIRTHPLACE (State or foreign country): Princess Anne Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Hayman

14. MOTHER'S MAIDEN NAME: Martha Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 215-16-8353

17. INFORMANT & ADDRESS: Minnie Hayman (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death: 3 hours

Immediate cause (a) Cerebral Hemorrhage

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION**

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/24, 1954, to 10/22/, 1954, that I last saw the deceased alive on 10/22/, 1954, and that death occurred at 7:55 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wilbur R. Ellis, Jr. MD — ADDRESS Salisbury, Md. — DATE SIGNED 10-23-54

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 10-26-54 — NAME OF CEMETERY OR CREMATORY John Wesley Cemetery — LOCATION (City, town, or county) Princess Anne, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 10-25-54 — REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR William H. James Jr. — ADDRESS Princess Anne Md.

VS. A15

RECEIVED
OCT 27 1954
BUREAU V. S.

09874

09883

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place) 1/2

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Wicomico

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Salisbury

STREET ADDRESS (If rural, give location) Quantico Road R.R. #5

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ivan	Lane	Hinton	Oct.	30	1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White		May 20, 1930	24 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY:
Pipe Insulator	Stone Babcock Co.	Floyd, Va.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Charles W. Hinton	Alice E. Ratliff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	224-32-3778	Mrs Veda M. Hinton

18. MEDICAL CERTIFICATION Hyattsville

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Fractured skull	25 minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO	
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒
—		

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Highway	21c. (City or town)	(County)	(State)
		Salisbury	Wicomico	Maryland

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED While at work ☐	Not while at work ☒	21f. HOW DID INJURY OCCUR?
10	30	54	3P M.			Killed in auto accident

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Earl L. Kruger M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 10/31/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	11-2-54	Fort Lincoln Cemetery	Colman Manor, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11-31-54	Mary W. Holloway	W. W. Chambliss Co.	Riverdale, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09875 09884

CERTIFICATE OF DEATH

Reg. Dist. No. 932

1. PLACE OF DEATH:
COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (in this place): All life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: At home - W. Lincoln St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
STREET ADDRESS (If rural give location): W. Lincoln Street

3. NAME OF DECEASED: (Type or Print) (First) Diane (Middle) Elizabeth (Last) Holbrook

4. DATE OF DEATH: (Month) 10 (Day) 13 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: A.A.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Baby

8. DATE OF BIRTH: 6-24-'54

9. AGE last birthday: yrs. — IF UNDER 1 YEAR: Months 3, Days 16 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Baby

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): P.G.H. Salisbury, Maryland

12. CITIZEN OF WHAT COUNTRY? Baby

13. FATHER'S NAME: William Holbrook

14. MOTHER'S MAIDEN NAME: Mary Lyda Finney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Baby
(If Yes, give war or dates of service): Baby

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: William Holbrook, W. Lincoln St. Salisbury, Md.

18. MEDICAL CERTIFICATION

19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
571.
Immediate cause (a) Diarrhea Cause undetermined — DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO
(c)

Interval Between Onset And Death: 2 days.

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT (Specify) / SUICIDE / HOMICIDE

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11 Oct., 1954, to 13 Oct., 1954, that I last saw the deceased alive on 13 Oct, 1954, and that death occurred at 9:20 pm, from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED 14 Oct 54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 10-18-'54
NAME OF CEMETERY OR CREMATORY: Houston Cemetery
LOCATION (City, town, or county) (State): Salisbury, Wicomico Co., Md.

DATE REC'D BY LOCAL REGISTRAR: 10-20-54
REGISTRAR'S SIGNATURE: Mary M. Holloway

24. FUNERAL DIRECTOR: Mary A. Stewart
ADDRESS: 324 E. Church Street

J.F. STEWART FUNERAL HOME Salisbury, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

OCT 22 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09885

09876 **CERTIFICATE OF DEATH** Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place) 1 yr

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Somerset

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eden Route #2.

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH: (Month) (Day) (Year)	
(Type or Print) Lee W. Ingersol	October 4	1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White		Mar. 16, 1878	76 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming	Own Farm	Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
John S. Ingersol	Amelia Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	none	Waller Ingersol

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Lobular Pneumonia	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Arteriosclerotic Cardiovascular Renal	16 yrs
	DUE TO (c) Cerebral Vascular accident	4 yrs

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Hx. Inguinal Hernia. 16 yrs

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 9-26, 1954, to 10-4, 1954 that I last saw the deceased alive on 10-4, 1954 and that death occurred at 12:30 P m., from the causes and on the date stated above.

SIGNATURE [signature] (DEGREE OR TITLE) ADDRESS 220 N. Division St DATE SIGNED 10-6-54

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	10-6-54	Allen Cemetery	Allen, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-6-54	Mary W. Holloway	Levin R. Wilson Per M.W.H.	Princess Anne, Md.

RECEIVED
OCT 8 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09886

09903 CERTIFICATE OF DEATH Reg. Dist. No. 382

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN R.F.D. 2 Salisbury Md. LENGTH OF STAY (in this place) 11 mos - 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deers Head Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R.F.D. 2, Salisbury Md.
STREET ADDRESS (If rural, give location) R.F.D. 2

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) William (Last) Jackson

4. DATE OF DEATH: (Month) 10 (Day) 20 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: July 3 - 1884

9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR: Months 3 Days 17 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Jackson

14. MOTHER'S MAIDEN NAME: Mary Church

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Generalized carcinomatosis

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Ca of mediastinum

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH: ?

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/16, 19 53 to 10/20, 19 54, that I last saw the deceased alive on 10/19, 19 54 and that death occurred at 1:45 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

N. Mulcahy, M.D. Dr. Richard H. Thorp, Salisbury Md. 10/20/54

23. BURIAL, CREMATION REMOVAL (Specify): DATE THEREOF 10-23-1954 NAME OF CEMETERY OR CREMATORY Green Tree Memorial Park LOCATION (City, town, or county) Salisbury (State) Md

DATE REC'D BY LOCAL REG. 10-25-54 REGISTRAR'S SIGNATURE Mary M. Holloway

24. FUNERAL DIRECTOR Mary A. Stewart ADDRESS 324 E. Church St.

J.E. STEWART FUNERAL HOME Salisbury, Md.

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

OCT 27 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09904 **CERTIFICATE OF DEATH**

19887

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 27 days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural, give location) 1005 N. Division Str.

3. NAME OF DECEASED: (First) HELEN (Middle) A. (Last) JOHNSON.

4. DATE OF DEATH: (Month) Oct. (Day) 17 (Year) 1954

5. SEX: F.

6. COLOR OR RACE: N.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: July 4, 1887

9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): SALISBURY, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Johnson.

14. MOTHER'S MAIDEN NAME: FANNY Dixon.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Generalized Carcinomatosis — Interval between onset and death: Unknown

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO (b) Adenocarcinoma of rectum. — —

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Cardiovascular disease — —

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/20, 1954, to 10/17, 1954, that I last saw the deceased alive on 10/17, 1954, and that death occurred at 7 15 P.m., from the causes and on the date stated above.

SIGNATURE D V Sherman (DEGREE OR TITLE) M.D. ADDRESS Deer's Head Hospital, Salisbury DATE SIGNED 10/17/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 10-21-1954

NAME OF CEMETERY OR CREMATORY Green Acre Memorial Park

LOCATION (City, town, or county) Salisbury (State) Maryland

DATE REC'D BY LOCAL REGISTRAR 10-20-54

REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR ADDRESS Mary A. Stewart 324 E. Church St.

J. F. STEWART FUNERAL HOME Salisbury, Md.

OCT
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09888

Dr. Burton 09877

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1 PLACE OF DEATH:
COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital 10

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 1
STREET ADDRESS (If rural give location) Hearn Bldg. N. Division St

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) PAUL (Last) KELLY
4. DATE OF DEATH: (Month) OCT (Day) 8 th (Year) 19 54

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Jan 15, 1885
9. AGE last birthday: 69 yrs.
IF UNDER 1 YEAR: Months 8 Days 23
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Foreman Shipping Dept.
10b. KIND OF BUSINESS OR INDUSTRY: Manhatten Shirt Factory
11. BIRTHPLACE (State or foreign country): Salisbury, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Kelly (Born Ireland)
14. MOTHER'S MAIDEN NAME: Fannie Collins (Born Ireland)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Mr. Albert Disharoon (Brother In Law)

18. MEDICAL CERTIFICATION Salisbury, Maryland

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause	(a) Myocardial infarction, extensive. DUE TO	7 days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) Generalized arterio-sclerosis. DUE TO	Years
	(c)	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/2, 19 54, to 10/8, 19 54, that I last saw the deceased alive on 10/8, 19 54, and that death occurred at 8:40 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
H.D. E. Church & Broad Sts. Salisbury, Md. Oct. 9 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Oct. 11, 1954
NAME OF CEMETERY OR CREMATORY Parsons Cemetery
LOCATION (City, town, or county) Salisbury, Maryland (State)

DATE REC'D BY LOCAL REGISTRAR 10-11-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY
ADDRESS SALISBURY MARYLAND
Walter R. Holloway
Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

OCT 13 1954
BUREAU V. S.

09905

09889

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 335

1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mardela

LENGTH OF STAY (in this place) 30 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS Double Mills

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY Wicomico

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Mardela

STREET ADDRESS (If rural, give location) Double Mills

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Edwin (Last) Knowles

4. DATE OF DEATH (Month) Oct (Day) 7 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 9, 1890

9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William James Knowles

14. MOTHER'S MAIDEN NAME: Jeanette English

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 218-245-895

17. INFORMANT & ADDRESS: Mrs Charles Knowles

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: Sudden

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Arterio-sclerotic C.V. Disease — Years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.,

21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Earl L Roy M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☑ ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 10-8-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 10/10/54

NAME OF CEMETERY OR CREMATORY Firemens

LOCATION (City, town, or county) (State) Sharptown, MD

DATE REC'D BY LOCAL REG. 10/10/54

REGISTRAR'S SIGNATURE Mary E. Owens

24. FUNERAL DIRECTOR Paul J. Smith, Sharptown, MD ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

RECEIVED
OCT 1[illegible]
BUREAU V. S.

09890

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09878

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place) 9 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE New Jersey — COUNTY Camden
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Haddenfield
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Irwin (Middle) Radcliffe (Last) Layman

4. DATE OF DEATH: (Month) 10 (Day) 13 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: July 9, 1884

9. AGE last birthday: 70 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Underwriter

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alonzo Layman

14. MOTHER'S MAIDEN NAME: Ella Hale

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 159-05-2322

17. INFORMANT & ADDRESS: Mrs David J Gilmore - Salisbury Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary thrombosis. — Interval Between Onset And Death

DUE TO

Antecedent causes (s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last.

(b) Arteriosclerotic Cardiovascular Disease. — 2 Years

DUE TO

(c) Benign prostatic hypertrophy

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None — **19b. MAJOR FINDINGS OF OPERATION**

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..., 19 ..., to ..., 19..., that I last saw the deceased alive on ..., 19 ..., and that death occurred at ..., from the causes and on the date stated above.

SIGNATURE William G. Johnson Jr. (Degree or title) — ADDRESS Salisbury Md. — DATE SIGNED 10-15-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 10/16/54 — NAME OF CEMETERY OR CREMATORY Monument Cemetery — LOCATION (City, town, or county) (State) Beverly, New Jersey

DATE REC'D BY LOCAL REGISTRAR 10-15-54 — REGISTRAR'S SIGNATURE Maryll Holloway — **24. FUNERAL DIRECTOR** The Hill & Johnson Co. Salisbury, Md. George C. Hill II — ADDRESS

RECEIVED
- 1 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09906

CERTIFICATE OF DEATH

09891

Reg. Dist. No. 337

1. PLACE OF DEATH: Deer's Head Hospital
COUNTY Nicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Talbot
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
STREET ADDRESS (If rural give location) R.D. 4

3. NAME OF DECEASED: (Type or Print) (First) Annie (Middle) L. (Last) Longnecker

4. DATE OF DEATH: (Month) Oct. (Day) 3 (Year) 1954

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 10-1-1864
9. AGE last birthday: 90 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (State or foreign country): Clear Ridge - Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Longnecker
14. MOTHER'S MAIDEN NAME: Mary You

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) None
16. SOCIAL SECURITY No.: Unknown
17. INFORMANT & ADDRESS: Francis A. Schwarzinger Easton, Md. Rt 4

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Cardiac insufficiency — Interval Between Onset And Death 48 h

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hypertensive cardiovascular disease — ?

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Obesity — ?

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/29, 1954, to 10/31, 1954, that I last saw the deceased alive on 10/31, 1954, and that death occurred at 10 50 AM, from the causes and on the date stated above.

SIGNATURE (Degree or Title) J. V. Malone, M.D. ADDRESS Salisbury Md. Deer's Head St. Hosp. DATE SIGNED 10/8/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Oct. 6 '54
NAME OF CEMETERY OR CREMATORY Fairview Cemetery
LOCATION (City, town, or county) (State) Talbot Co., R.D. Md.

DATE REC'D BY LOCAL REGISTRAR 10-4-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR W. Frampton Carroll ADDRESS Easton, Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

I

OCT 6 1
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09907 CERTIFICATE OF DEATH

Reg. Dist. No. 09892

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY WICOMICO
CITY (If outside corporate limits, write RURAL) OR TOWN SHARPTOWN X
LENGTH OF STAY (in this place) 74yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS NEAR SHARPTOWN

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD COUNTY WICOMICO
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SHARPTOWN X
STREET ADDRESS (If rural give location) NEAR SHARPTOWN

3. NAME OF DECEASED: (Type or Print) (First) ARTHUR (Middle) WILLIS (Last) MARINE

4. DATE OF DEATH: (Month) OCT (Day) 11 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH: APRIL 3 1873

9. AGE last birthday: 81 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARM OWNER

11. BIRTHPLACE (State or foreign country): DELAWARE

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: JAMES F MARINE

14. MOTHER'S MAIDEN NAME: JULIA ANN ROBINSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: NONE

17. INFORMANT & ADDRESS: MRS ARTHUR MARINE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) DUE TO: coronary thrombosis — Interval Between Onset And Death: ½ hour

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO: coronary and generalized arterio-sclerosis — 2
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 11, 1954, to Oct 11, 1954, that I last saw the deceased alive on Oct 11th, 1954, and that death occurred at ....., from the causes and on the date stated above.

SIGNATURE (Degree or Title) X.V. Soder M.D. ADDRESS Delmar, Md. DATE SIGNED 10-12-54

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL — DATE THEREOF 10/13/54 — NAME OF CEMETERY OR CREMATORY FIREMENS — LOCATION (City, town, or county) SHARPTOWN (State) MD

DATE REC'D BY LOCAL REGISTRAR 10/13/54 — REGISTRAR'S SIGNATURE Mary C Owens

24. FUNERAL DIRECTOR Paul J Smith, Sharptown Md ADDRESS

VS. A15

RECEIVED
OCT 18 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09893

09908

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SALISBURY X
LENGTH OF STAY (in this place) 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS DEER'S HEAD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY TALBOT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TRAPPE
STREET ADDRESS (If rural, give location) RFD#1

3. NAME OF DECEASED: (Type or Print) (First) MILLIE (Middle) JANE (Last) MARSHALL

4. DATE OF DEATH: (Month) OCT. (Day) 4th (Year) 1954.

5. SEX: FEMALE
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: DEC. 13th 1879
9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): DORCHESTER, Md. USA.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: JOHN JONES
14. MOTHER'S MAIDEN NAME: MILLIE NEAL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: HOSPITAL RECORDS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
Immediate cause	(a)	CEREBRAL THROMBOSIS c̄. rt. hemiplegy	12 days
	DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	Arteriosclerosis cerebral a. general	?
	DUE TO		
	(c)		

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic cardiovascular disease ?

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9.9, 1952, to 10.4, 1954, that I last saw the deceased alive on 10.4, 1954, and that death occurred at 5:18 p.m., from the causes and on the date stated above.

SIGNATURE Dr. Vuerman (DEGREE OR TITLE) M.D. ADDRESS Deer's Head State Hospital, Salisbury Md. DATE SIGNED 10.4.54

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF Oct. 7 1954
NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery
LOCATION (City, town, or county) (State) Easton, Talbot, Maryland

DATE REC'D BY LOCAL REG. 10/6/54
REGISTRAR'S SIGNATURE N. H. Neeney
24. FUNERAL DIRECTOR Maurice F. Neuman & Son
ADDRESS Easton, Maryland

10-7-54 Mary W. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

RECEIVED
OCT 11 1954
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09894

Dr. William Smith 09879 **CERTIFICATE OF DEATH** Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (in this place) 12
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. D. # 3

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
STREET ADDRESS (If rural give location) R. D. # 3

3. NAME OF DECEASED: (Type or Print) (First) MILDRED (Middle) ELIZABETH (Last) MC HUGH

4. DATE OF DEATH: (Month) OCT (Day) 31 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Nov. 18, 1907

9. AGE last birthday: 46 yrs. IF UNDER 1 YEAR Months 0 Days 13 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) House Wife

10b. KIND OF BUSINESS OR INDUSTRY: At own home

11. BIRTHPLACE (State or foreign country): Delmar Maryland

12. CITIZEN OF WHAT COUNTRY? Usa

13. FATHER'S NAME: E. Slemons Ellis

14. MOTHER'S MAIDEN NAME: Etha Culver

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mr. John E. Mc Hugh (Husband) R.D. # 3

18. MEDICAL CERTIFICATION Salisbury, Maryland

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Uremia — Interval Between Onset And Death

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Metastatic Carcinoma

DUE TO

(c) Carcinoma Cervix

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1954 to 10-31, 1954, that I last saw the deceased alive on 10-31, 1954, and that death occurred at 9 P M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm B. Smith M.D. ADDRESS Salisbury, Maryland DATE SIGNED Nov. 3 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Nov. 3, 1954 NAME OF CEMETERY OR CREMATORY Parsons Cemetery LOCATION (City, town, or county) Salisbury, Maryland (State)

DATE REC'D BY LOCAL REGISTRAR 11-3-54 REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND

Walter R Holloway Walter R. Holloway

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09895

09909 CERTIFICATE OF DEATH

Reg. Dist. No. 325

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mardela
LENGTH OF STAY (in this place) 50 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mardela
STREET ADDRESS (If rural give location) Main St

3. NAME OF DECEASED: (Type or Print) (First) Edna (Middle) (Last) Owens

4. DATE OF DEATH: (Month) Oct (Day) 22 (Year) 1954

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Feb 11, 1878
9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: School Teacher
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): MD
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Doughty B. Owens
14. MOTHER'S MAIDEN NAME: Minerva Bennett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Mrs Blanche Robinson

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma - Colon - Immunoactivity — Interval Between Onset And Death: 18 months

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1952, to Oct 21, 1954, that I last saw the deceased alive on Oct 21, 1954, and that death occurred at 6 P.M., from the causes and on the date stated above.

SIGNATURE H. B. Kuhlmann (Degree or title) MD ADDRESS Sharptown Md DATE SIGNED 10/24/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Oct 24, 1954
NAME OF CEMETERY OR CREMATORY Mardela Cemetery
LOCATION (City, town, or county) (State) Mardela Springs, MD
DATE REC'D BY LOCAL REGISTRAR 10-24-54
REGISTRAR'S SIGNATURE Mary C Owens
24. FUNERAL DIRECTOR Paul J Smith ADDRESS Sharptown Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09896

09880 **CERTIFICATE OF DEATH**

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Wicmico — MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Salisbury

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Wicomico

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jesterville

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (First) (Middle) (Last) Parsons

4. DATE OF DEATH: (Month) 10 (Day) 11 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 10-10-54

9. AGE last birthday: yrs. IF UNDER 1 YEAR: Months | Days IF UNDER 24 HRS.: Hours 11 | Min. 3

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Walter James Parsons

14. MOTHER'S MAIDEN NAME: Mildred Delores Hastings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 1

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Walter J. Parsons

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Immaturity — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) — DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/10..., 1954, to 10/11..., 1954, that I last saw the deceased alive on..... 19....., and that death occurred at 6:25 A.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Rivers Hanson MD ADDRESS Salisbury, Md DATE SIGNED 10-12-54

23. BURIAL, CREMATION REMOVAL (Specify): DATE THEREOF 10-12-54. NAME OF CEMETERY OR CREMATORY Peninsula General Hospital LOCATION (City, town, or county) (State) Salisbury, Wicomico md.

DATE REC'D BY LOCAL REG. 10-12-54 REGISTRAR'S SIGNATURE Mary M. Holloway

24. FUNERAL DIRECTOR Peninsula General Hospital ADDRESS

RECEIVED
OCT 14 1954
BUREAU V. S.

09881

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09897

CERTIFICATE OF DEATH

Reg. Dist. No. 332

Items 2,9,FilmG171 10-19-54 et

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY
LENGTH OF STAY (In this place) 17 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS John B. Parsons Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
STREET ADDRESS (If rural give location) Correct John B Parson Home

3. NAME OF DECEASED: (Type or Print) (First) ANNIE (Middle) (Last) PHILLIPS

4. DATE OF DEATH: (Month) 10 (Day) 8 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Oct 28, 1875
9. AGE last birthday: 79 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: House Keeper
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Asbury Phillips
14. MOTHER'S MAIDEN NAME: Emmily V. Parsons

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: John B Parsons Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute coronary occlusion — Interval Between Onset And Death: 5 mins.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Generalized arteriosclerosis — Years

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/2, 1954, to 10/8/1954, that I last saw the deceased alive on 10/2, 1954, and that death occurred at 7.15 pm, from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) M.D. ADDRESS Salisbury DATE SIGNED 10/9/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 10/10/54
NAME OF CEMETERY OR CREMATORY Parsons Cemetery
LOCATION (City, town, or county) Salisbury, (State) Maryland
DATE REC'D BY LOCAL REGISTRAR 10-9-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR THE HILL & JOHNSON CO ADDRESS SALISBURY
George C Hill II

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 19 1914
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09898

09882 **CERTIFICATE OF DEATH** Reg. Dist. No. 333

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 115 W. Fort Avenue

3. NAME OF DECEASED: (Type or Print) (First) CLARENCE (Middle) (Last) POOLE

4. DATE OF DEATH: (Month) October (Day) 5 (Year) 1954

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Sept 21, 1893
9. AGE last birthday: 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Mover
10b. KIND OF BUSINESS OR INDUSTRY: Norman Slippe Storage Co
11. BIRTHPLACE (State or foreign country): Balto
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Curt S. Poole
14. MOTHER'S MAIDEN NAME: Mary Frank

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (I[illegible] ar or date of servi[illegible]
16. SOCIAL SECURITY NO.: 217-09-4221
17. INFORMANT & ADDRESS: Bertha J. Poole 115 W. Fort Ave

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
332X
Immediate cause (a) Cerebral Thrombosis
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)
DUE TO
(c)
Interval Between Onset And Death 4 days

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-1, 1954, to 10-5, 1954 that I last saw the deceased alive on 10-5, 1954, and that death occurred at 7:40 P.M. from the causes and on the date stated above.
SIGNATURE (Degree or title) William R. Ellis, Jr. MD
ADDRESS Salisbury, Md
DATE SIGNED 10-6-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Oct 8, 1954
NAME OF CEMETERY OR CREMATORY Cedar Hill
LOCATION (City, town, or county) A. A. Co. (State) Md
DATE REC'D BY LOCAL REGISTRAR 10-7-54
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR A. Howard Evans
ADDRESS 140 W. St Charles

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09883 09899

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula Funeral Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Carrie (Middle) H (Last) Root

4. DATE OF DEATH: (Month) October (Day) 31 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: APRIL 15, 1870
9. AGE last birthday: 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): UT.
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: CHARLES DURPHEY
14. MOTHER'S MAIDEN NAME: UNKNOWN

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: NONE
17. INFORMANT & ADDRESS: Mr Paul J. Smith, Sharptown Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiovascular renal disease
DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)
DUE TO
(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour)
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 15, 1954, to Oct 31, 1954, that I last saw the deceased alive on Oct 31, 1954, and that death occurred at 3:50 PM, from the causes and on the date stated above.
SIGNATURE Philip A. Fisher (Degree or title) MD ADDRESS Salisbury Md DATE SIGNED 11-1-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 11/5/54
NAME OF CEMETERY OR CREMATORY Quechee
LOCATION (City, town, or county) Quechee (State) UT
DATE REC'D BY LOCAL REGISTRAR 11-8-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Paul J. Smith, Sharptown, Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09990

09884 CERTIFICATE OF DEATH Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Delaware COUNTY Sussex
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Seaford
STREET ADDRESS (If rural give location) West manor Apts-N-18

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) Schaefer

4. DATE OF DEATH: (Month) October (Day) 5 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: October 5-1954

9. AGE last birthday: yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Wesley E. Schaefer

14. MOTHER'S MAIDEN NAME: Joyce Esther Richardson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Wesley Schaefer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.5
Immediate cause (a) Massive Fetal Atelectasis

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Pre-maturure Circulatory System

DUE TO

(c) Pre maturity

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes X No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/5/54, to 10/5/54, that I last saw the deceased alive on 10/5, 1954, and that death occurred at 10:45 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Luther Lee Booker M.D. Salisbury Md. 10-6-54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

10-6-54 Peninsula General Hospital Salisbury Wicomico Md.

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE

10-6-54 Mary W. Holloway

24. FUNERAL DIRECTOR ADDRESS

Peninsula General Hospital

20042612

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 8 1971
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09901

CERTIFICATE OF DEATH

09910

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (in this place): 9 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Deer's Head State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Queen Anne's
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Stevensville, Md.
STREET ADDRESS (If rural, give location): --

3. NAME OF DECEASED: (First) alethea (Middle) Sewell (Last) .

4. DATE OF DEATH: (Month) 10 (Day) 30 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct. 13, 1907

9. AGE last birthday: 47 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Aleatha Spence

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) --

16. SOCIAL SECURITY NO.: --

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

42

Immediate cause (a) Myocardial Insufficiency due — Interval Between Onset and Death: 9 days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) to Arteriosclerotic Heart — 2

DUE TO

(c) disease

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Status Post amputation right leg 4 weeks.

19a. DATE OF OPERATION: -

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-21, 1954, to 10-30, 1954, that I last saw the deceased alive on 10-29, 1954 and that death occurred at 2:30 P.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

R L Sore MD Peninsula Hospital 10-30-54

23. BURIAL / CREMATION / REMOVAL (Specify): — DATE THEREOF: 11/3/54 — NAME OF CEMETERY OR CREMATORY: Stevensville — LOCATION (City, town, or county) (State): Stevensville, Md.

DATE REC'D BY LOCAL REG. 11-1-54 — REGISTRAR'S SIGNATURE: Mary W. Holloway

24. FUNERAL DIRECTOR: Edgar L. Lane — ADDRESS: Church Hill Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09902

09911

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Wicomico — STATE MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Salisbury
LENGTH OF STAY (in this place) 3 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula St Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Calvert.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Prince Frederick.
STREET ADDRESS — (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Edward (Middle) (Last) Slye.

4. DATE OF DEATH: (Month) 10 (Day) 31 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S

8. DATE OF BIRTH: 7-3-71

9. AGE last birthday: 83 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Calvert County, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Hepatic Coma — Interval Between Onset and Death: 3 days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Obstructive Biliary Cirrhosis — 2

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, Gen. ?

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-7 1951, to 10-31 1954, that I last saw the deceased alive on 10-30 1954, and that death occurred at 1:15 A.m., from the causes and on the date stated above.

SIGNATURE R Shore MD (DEGREE OR TITLE) ADDRESS Peninsula Hospital DATE SIGNED 10-31-54

23. BURIAL, CREMATION, REMOVAL (Specify): DATE THEREOF 11-3-54 NAME OF CEMETERY OR CREMATORY Maryland Anatomical Board LOCATION (City, town, or county) Baltimore (State) Md

DATE REC'D BY LOCAL REG. 3-3-4 REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Geo. C. Richards ADDRESS

09885 09913

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Phys[illegible]: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 400 Grady Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Wicomico
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Salisbury, Maryland
STREET ADDRESS (If rural, give location) 400 Grady Street.

3. NAME OF DECEASED: (Type or Print) (First) Harold (Middle) Lee (Last) Smith

4. DATE OF DEATH (Month) 10 (Day) 14 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Feb. 25 1885

9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Farm Railroad

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Napoleon B. Smith

14. MOTHER'S MAIDEN NAME: Arlena Elliott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Mary E. C. Smith Salisbury, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Earl L. Royer M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☑

DATE SIGNED 10-16-54

23. BURIAL, ~~CREMATION~~, REMOVAL (Specify): Burial

DATE THEREOF 10/17/54

NAME OF CEMETERY OR CREMATORY Mt Olive

LOCATION (City, town, or county) (State) Delmar Del

DATE REC'D BY LOCAL REG. 10-18-54

REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR ADDRESS W. L. Mavel Co. Delmar, Del

VS. A15A - 5 - 53

09886 09904

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place): 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS P. G. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Snow Hill
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) JAMES (Middle) C. (Last) SMITH
4. DATE OF DEATH (Month) Oct. (Day) 16 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: July 19-1880
9. AGE last birthday: 74/2/27 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Tenant Farmer
11. BIRTHPLACE (State or foreign country): Oak Hall Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Noah Smith
14. MOTHER'S MAIDEN NAME: Susan Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: Mr James G Smith 122 Alcock Rd Baltimore 21 Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) DUE TO Cerebral Vascular Accident	1 day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Hurricane Accident (struck on head by flying debris)	1 day
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 2
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Public
21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) Oct. (Day) 15 (Year) 54 (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE J. Bentley La Mar M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ DATE SIGNED 10-17-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF Oct. 19/54
NAME OF CEMETERY OR CREMATORY Taylor
LOCATION (City, town, or county) Temperanceville Va. (State)

DATE REC'D BY LOCAL REG. 10-19-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Clay Hammond, Snow Hill
ADDRESS Md

VS. A15A - 5 - 53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09912 **CERTIFICATE OF DEATH** Reg. Dist. No. 332

1. PLACE OF DEATH: Willards
COUNTY Wicomico County MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards Md. X
LENGTH OF STAY (in this place) 15 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Md.
STREET ADDRESS (If rural give location) 1827 Patterson Park Ave.

3. NAME OF DECEASED: (Type or Print) (First) Robert (Middle) Burns (Last) Smith
4. DATE OF DEATH (Month) Oct. (Day) 28 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower
8. DATE OF BIRTH: Aug. 16, 1869.
9. AGE last birthday 18.6 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanical Jewelry
10B. KIND OF BUSINESS OR INDUSTRY: Store
11. BIRTHPLACE (State or foreign country): X Territorial Waters [illegible]
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: X Robert B. Smith
14. MOTHER'S MAIDEN NAME: X Mary (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No
16. SOCIAL SECURITY NO. No.
17. INFORMANT & ADDRESS: Doely Davis Willards Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Apoplexy (cerebral hemorrhage) — 2 yrs ago.

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Aug 25, 1953, to 10-28, 1954, that I last saw the deceased alive on 10-27, 1954 and that death occurred at 2 A. M, from the causes and on the date stated above.

SIGNATURE Frank R. Lewis M.D. ADDRESS Willards Md DATE SIGNED 10-28-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10/31/54
NAME OF CEMETERY OR CREMATORY Evergreen
LOCATION (City, town, or county) Berlin (State) Md

DATE REC'D BY LOCAL REGISTRAR 11-1-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR [illegible] Burbage
ADDRESS Berlin Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09887 09906

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 12
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 12
STREET ADDRESS (If rural give location) 606 Jackson St

3. NAME OF DECEASED: (Type or Print) (First) ELISHA (Middle) BRIERLEY (Last) STEERE

4. DATE OF DEATH: (Month) OCT (Day) 10 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: July 20, 1874

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) Interior Decorator

10b. KIND OF BUSINESS OR INDUSTRY: (Decorating)

11. BIRTHPLACE (State or foreign country): Rhode Island

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Harrison Steere

14. MOTHER'S MAIDEN NAME: Helen Isabella Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mrs Ernestine E. Steere (Wife) 606 Jackson St

18. MEDICAL CERTIFICATION Salisbury, Maryland

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 420.0 (a) Congestive Heart Failure DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO

(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/5/51, 19 ....., to 10/10, 1954, that I last saw the deceased alive on 10/10, 1954, and that death occurred at 11:25 P.M., from the causes and on the date stated above.

SIGNATURE Fred R. Grange (Degree or title) ADDRESS S. Divison St. Salisbury, Maryland DATE SIGNED Oct. 13 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Oct. 13, 1954 NAME OF CEMETERY OR CREMATORY Bethel Cemetery LOCATION (City, town, or county) (State) Walston Maryland

DATE REC'D BY LOCAL REGISTRAR 10-13-54 REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 15 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0913

CERTIFICATE OF DEATH

19907

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN SALISBURY — LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md — COUNTY Queen Anne's

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chester

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Carrie (Middle) (Last) Thomas

4. DATE OF DEATH: (Month) Oct. (Day) 11 (Year) 1954

5. SEX: F

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 5/7/1876

9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): CHESTER, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS THOMPSON

14. MOTHER'S MAIDEN NAME: MOLLY BAXTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No

(If Yes, give war or dates of service) None

16. SOCIAL SECURITY NO.: None.

17. INFORMANT & ADDRESS: HOSPITAL RECORDS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Recurrent cerebral hemorrhage	15 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Hypertensive vascular disease	10 years
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Cardiovascular disease ?

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION:**

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/11, 1954, to 10/11, 1954, that I last saw the deceased alive on 10/11, 1954, and that death occurred at 9 50 P.m., from the causes and on the date stated above.

SIGNATURE Dr. V. Juerman (DEGREE OR TITLE) M.D. ADDRESS Deer's Head State Hospital, Salisbury, Md DATE SIGNED 10/11/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF Oct 14-54 — NAME OF CEMETERY OR ~~CREMATORY~~ Stemmers — LOCATION (City, town, or county) (State) Stemmers, Maryland

DATE REC'D BY LOCAL REG. 10-13-54 — REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Barton Bros — ADDRESS Centreville, Maryland

RECEIVED
OCT 15 1
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09908

09888

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula Gen. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Dam
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Fanny (Middle) (Last) TILGHMAN

4. DATE OF DEATH: (Month) 10 (Day) 12 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: Oct 14, 1891
9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10b. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (State or foreign country): Somerset Co., Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Hayward
14. MOTHER'S MAIDEN NAME: Henrietta Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 219-07-6487
17. INFORMANT & ADDRESS: Cecilia Dennis, Princess Ann, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X

Immediate cause (a) Cerebral Thrombosis — Interval Between Onset And Death: 1 week

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-8, 1954, to 10-12, 1954 that I last saw the deceased alive on 10-12, 1954, and that death occurred at 2:08 AM., from the causes and on the date stated above.

SIGNATURE (Degree or title) Willem R. Ellis, Jr. MD
ADDRESS Salisbury, Md.
DATE SIGNED 10-12-54

23. BURIAL, CREMATION, REMOVAL (Specify)
DATE THEREOF 10-17-54
NAME OF CEMETERY OR CREMATORY Mt Hope Cemetery
LOCATION (City, town, or county) Princess Anne, Md (State)

DATE REC'D BY LOCAL REGISTRAR 10-13-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR William H. Jones Jr.
ADDRESS Princess Anne Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 15 19[illegible]
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09909

09889

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland. COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin
STREET ADDRESS (If rural give location) Rt. #2.

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) Tingle

4. DATE OF DEATH: (Month) (Day) (Year) October 11 1954.

5. SEX: Male
6. COLOR OR RACE: Colored.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: October 11-1954
9. AGE last birthday: yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 4 Min. 49

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country).
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Pauline Virginia Tingle

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Pauline Tingle, Berlin, Md. Rt. #2

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

7-25

Immediate cause (a) Partial Atelectasis

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Immaturity

DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 11, 1954, to Oct 11, 1954, that I last saw the deceased alive on Oct 11, 1954, and that death occurred at 1:25 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Rivers Hanson MD
ADDRESS Salisbury
DATE SIGNED 10-12-54

23. BURIAL, CREMATION, REMOVAL (Specify)
DATE THEREOF 10/13/54
NAME OF CEMETERY OR CREMATORY Peninsula General Hospital
LOCATION (City, town, or county) (State) Salisbury Md

DATE REC'D BY LOCAL REGISTRAR 10-13-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Peninsula General Hospital
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A1

RECEIVED
OCT 15 19[illegible]
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09910

Dr. Beardsley 09914 **CERTIFICATE OF DEATH** Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville X
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Delaware Rd. ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville ✓
STREET ADDRESS (If rural give location) Delaware Rd

3. NAME OF DECEASED: (Type or Print) (First) ANNA (Middle) ELIZABETH (Last) TRUITT

4. DATE OF DEATH: (Month) OCT (Day) 1 st (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Sept. 12, 1856

9. AGE last birthday: 98 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Pittsville, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: B. Fooks Farlow

14. MOTHER'S MAIDEN NAME: Elizabeth Hearn

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mr. Lee F. Truitt (Son) R.D. # 5 Maple Way Salisbury, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Thrombosis — Interval Between Onset And Death: 6 mos.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 19 54, to Oct. 1, 19 54, that I last saw the deceased alive on Sept. 30 19 54, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or Title) Paul M. Beardsley M.D. ADDRESS East Church St. Salisbury, Maryland DATE SIGNED Oct. 3 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Oct. 4, 1954 — NAME OF CEMETERY OR CREMATORY Farlow Cemetery — LOCATION (City, town, or county) (State) R.D. Pittsville, Maryland

DATE REC'D BY LOCAL REGISTRAR 10-3-54 — REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR ADDRESS HOLLOWAY & COMPANY SALISBURY MARYLAND

Walter R. Holloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09911

Dr. Wm. Smith 09890

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 17
HOSPITAL OR INSTITUTION OR STREET ADDRESS 606 Waverly Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) 606 Waverly Ave.

3. NAME OF DECEASED: (Type or Print) (First) RUBY (Middle) MARIA (Last) VAN HORN

4. DATE OF DEATH: (Month) OCT. (Day) 4 th (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: July 24, 1880

9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR: Months 2 Days 10 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: House Work

10b. KIND OF BUSINESS OR INDUSTRY: At Own Home

11. BIRTHPLACE (State or foreign country) Roaring Branch Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Geiger

14. MOTHER'S MAIDEN NAME: Celia Maria Rockwell

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Harry L. Van Horn(Husband) Oneida, New York

18. MEDICAL CERTIFICATION Curtis R. Geiger-Salisbury, Maryland (Brother)

19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

443 X

Immediate cause (a) Coronary Occlusion

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Hypertensive C.V. Disease

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/5, 1954, to 10/5, 1954, that I last saw the deceased alive on 10/5, 1954, and that death occurred at 6:00 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. Roy B. Smith M.D. ADDRESS 222 N. Division St. Salisbury, Maryland DATE SIGNED Oct. 7 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Oct. 7, 1954 | NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park | LOCATION (City, town, or county) (State) Salisbury, Maryland

DATE REC'D BY LOCAL REGISTRAR 10-7-54 REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR ADDRESS HOLLOWAY & COMPANY SALISBURY MARYLAND

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 11 1954
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09891

CERTIFICATE OF DEATH

Reg. Dist. No. 332 — 1.9912

Dr. Gray

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 212 East Vine St

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural, give location) 212 East Vine St.

3. NAME OF DECEASED: (Type or Print) (First) WILLARD (Middle) JAMES (Last) WALLACE

4. DATE OF DEATH: (Month) Oct (Day) 19 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Jan 19, 1891

9. AGE last birthday: 63 yrs. — IF UNDER 1 YEAR: Months 9, Days 0 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Marine Co.

11. BIRTHPLACE (State or foreign country): Danes Quarter Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Correy Wallace

14. MOTHER'S MAIDEN NAME: Annie White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW I Army

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Della Wallace(Wife)212 E. Vine St.

18. MEDICAL CERTIFICATION Salisbury, Maryland

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause — (a) Coronary Occlusion — DUE TO — Interval Between Onset and Death: sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) Arteriosclerotic C-V Disease — DUE TO — Interval Between Onset and Death: 8 mos

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 19 54 to 10-19 19 54, that I last saw the deceased alive on 10-18 19 54, and that death occurred at 4:10 P.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) William D Gray M.D. ADDRESS Camden Ave Salisbury Md. DATE SIGNED Oct. 21 1954

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF Oct. 21, 1954

NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park

LOCATION (City, town, or county) Salisbury, Maryland (State)

DATE REC'D BY LOCAL REG. 10-21-54

REGISTRAR'S SIGNATURE Mary M. Holloway

24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND

Walter R. Holloway

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
BUREAU V

09892 09913

Item 21f [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 15 MINS
HOSPITAL OR INSTITUTION OR STREET ADDRESS Market St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Wicomico
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Salisbury R.
STREET ADDRESS (If rural, give location) Ocean City Blvd.

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
HOWARD	Perdue	WARD	10	15	19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
M	W		Feb. 8 1902	52 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Real Estate	Owner	Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
David J Ward	Edith Perdue

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
WW II	214-16-8441	D. J. Ward - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) FRACTURE DISLOCATION CERVICAL SPINE	
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☑
0		

21a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)	(State)
	Bldg	Salisbury	Wicomico	Md.

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED While at work ☑	Not while at work ☐	21f. HOW DID INJURY OCCUR?
10	15	1954	6 P.M.			Skating Rink Roof Fell on him during "Hurricane"

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Emil L Ruzzo M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 10-18-54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10/18/54	Parsons Cemetery	Salisbury, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-18-54	Mary W. Holloway	Hill and Johnson Co	George C. Weir II

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09914

09917 **CERTIFICATE OF DEATH** Reg. Dist. No. 332

1. PLACE OF DEATH: Deer's Head State Hospital
Salisbury, Md.
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury X
LENGTH OF STAY (in this place) 1 week
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital 70

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Snow Hill
STREET ADDRESS (If rural, give location) Martin Street

3. NAME OF DECEASED: (Type or Print) (First) Julia (Middle) -- (Last) Watson

4. DATE OF DEATH: (Month) October (Day) 15 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Sept. 26, 1865
9. AGE last birthday: 89 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hammer Zone
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Pocomoke City, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John E. Brittingham
14. MOTHER'S MAIDEN NAME: Mary Ann Dix

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unknown (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 443x

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Cardiac insufficiency	3 d
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO	Hypertensive cardiovasc. disease	?
	(c) DUE TO		

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteriosel. gen ?

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 10/7, 1954, to 10/15, 1954, that I last saw the deceased alive on 10/15, 1954, and that death occurred at 11 38 P.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
J. Malone, M.D. Salisbury Md. Deer's Head St. Hosp. 10/15/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF Oct. 18/54
NAME OF CEMETERY OR CREMATORY Presbyterian
LOCATION (City, town, or county) Snow Hill (State) Md

DATE REC'D BY LOCAL REG. 10-18-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Clay Timmins, Snow Hill
ADDRESS Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1

OCT 1954

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09915

09893 **CERTIFICATE OF DEATH** Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Delaware COUNTY Sussex
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel
STREET ADDRESS (If rural give location) Rt # 3

3. NAME OF DECEASED: (Type or Print) (First) Elwood (Middle) H (Last) Wheatley
4. DATE OF DEATH: (Month) 10 (Day) 28 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Aug. 31, 1898
9. AGE last birthday: 56 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Building Supply Co
11. BIRTHPLACE (State or foreign country): Galestown, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louder Wheatley
14. MOTHER'S MAIDEN NAME: Anna Wheatley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 221-12-4230
17. INFORMANT & ADDRESS: Alda B Wheatley

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
151 x
Immediate cause (a) Generalized peritonitis
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Generalized Abdominal Carcinomatosis
DUE TO
(c) c̄ origin from carcinoma of stomach.

Interval Between Onset And Death: continuous

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 10-23-54
19b. MAJOR FINDINGS OF OPERATION: Generalized Carcinomatosis of Abdomen.
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-21, 1954, to 10-28, 1954, that I last saw the deceased alive on 10-27, 1954, and that death occurred at 4 P.M., from the causes and on the date stated above.
SIGNATURE William H. Fisher Jr. (Degree or title) ADDRESS Salisbury DATE SIGNED Oct. 10-28

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 10-31-54 NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery LOCATION (City, town, or county) Laurel, Del (State)
DATE REC'D BY LOCAL REGISTRAR 10-30-54 REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR H. L. Dishawon, Laurel ADDRESS Del.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

09915 09916

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 335

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Hebron X
LENGTH OF STAY (in this place) 2 yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS Marion Dry Co

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD COUNTY Wicomico
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Hebron
STREET ADDRESS (If rural, give location) Railroad Hill

3. NAME OF DECEASED: (Type or Print) (First) Elisha (Middle) Elizabeth (Last) Wheatley

4. DATE OF DEATH (Month) (Day) (Year) 19

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: April 22, 1915
9. AGE last birthday: 39 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Ballard
14. MOTHER'S MAIDEN NAME: Hattie Manning

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: [illegible]
17. INFORMANT & ADDRESS: [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary Occlusion DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.,
21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Earl L. Royer M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 10-26-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 10/29/54
NAME OF CEMETERY OR CREMATORY Yellestown
LOCATION (City, town, or county) (State) [illegible]

DATE REC'D BY LOCAL REG. Oct 29, 1954
REGISTRAR'S SIGNATURE Mary C. Owens
24. FUNERAL DIRECTOR [illegible] ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

09916 MARYLAND STATE DEPARTMENT OF HEALTH 09917

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY Wicomico Co MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Willards X LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Near Willards Md
HOSPITAL OR INSTITUTION OR STREET ADDRESS none X	STREET ADDRESS (If rural, give location) None

3. NAME OF DECEASED (Type or Print) (First) Tillie (Middle) May Trinity (Last) Wilkins

4. DATE OF DEATH (Month) Oct (Day) 9 (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Female	White	Widowed	May 10 1870	84 4-29 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Town wife	none	Delaware	Wicomico

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Peter W. Murray	Santa Gault

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
0	none	Jessie Gray

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 wk.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arterio sclerosis — 5 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0		Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept 2, 1954, to Oct. 10, 1954, that I last saw the deceased alive on Oct. 9, 1954, and that death occurred at 8 40 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Earl M Bradley	M.D.	Pittsville, Md.	10-10-54

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct 12 1954	Lewis Cemetery	Near Willards	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-11-54	Mary W. Holloway	Wm Howard Wells	Pittsville Md

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 13 1954
BUREAU V. S.

09894

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10970

Reg. Dist. No. 350

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Worcester — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (In this place) 2 minutes
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: COUNTY Worcester — STATE Md
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Pocomoke City Md
STREET ADDRESS (If rural, give location) Ellen Jones Farm Hill 28K-7

3. NAME OF DECEASED (Type or Print): (First) Vivian (Middle) (Last) Wise
4. DATE OF DEATH: (Month) Oct (Day) 15 (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	C	Single	Sept 13-1941	13 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
School girl	At home	Pocomoke City Md.	U.S.A.

13. FATHER'S NAME Willie Wise
14. MOTHER'S MAIDEN NAME Leanie Jones.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkoown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		Emma Morgan (Grandmother) Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Broken neck and body injuries dislocated C5 & 6 vertebrae	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Due to a fall Dec 13-1941 from window to ground	
	(c) by a large pecan tree measuring the height of 70 feet approximately.	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office building, etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	At Home	Pocomoke City	Worcester	Md

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
Oct 15 1954 1:35 p.m.		Slipped by a fall from tree to ground Hazel Harrison

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Dr. W. R. Getorius	D.M.	Pocomoke City Md	10/16/54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-18-54	Wardtown	Pocomoke Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 18, 1954	Anne E. White	Edgar Wharton	New Church, Va.

VS-115A

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RECEIVED
OCT 20 1954
BUREAU V. S.